		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044164

Facility Name: CRESTWOOD CARE CENTRE

Address: 14255 S. CICERO AVE. (Number) CRESTWOOD (City) 60445 (Zip Code)

County: COOK

Telephone Number: (847) 371-0400 **Fax #** (847) 371-5871

IDPA ID Number: 36-3967295

Date of Initial License for Current Owners: 08/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHAEL BELLOWS

(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 03/19/2002

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3	208	Intermediate (ICF)	199	73,328	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	312	TOTALS	303	111,288	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,118	1,662	9,517	24,297	8
9	SNF/PED					9
10	ICF	51,043	6,456	6,356	63,855	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,161	8,118	15,873	88,152	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.21%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 33 and days of care provided 6,384

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	512,774	41,783	22,076	576,633		576,633	(69)	576,564			1
2	Food Purchase		334,822		334,822		334,822	(1,442)	333,380			2
3	Housekeeping	420,598	53,945		474,543		474,543	3,646	478,189			3
4	Laundry	150,508	30,572	6,440	187,520		187,520	1,578	189,098			4
5	Heat and Other Utilities			142,348	142,348		142,348		142,348			5
6	Maintenance	83,740	66,408	54,790	204,938		204,938	(3,366)	201,572			6
7	Other (specify):*			101,038	101,038		101,038		101,038			7
8	**TOTAL General Services**	1,167,620	527,530	326,692	2,021,842		2,021,842	347	2,022,189			8
	B. Health Care and Programs											
9	Medical Director			25,150	25,150		25,150		25,150			9
10	Nursing and Medical Records	3,190,592	184,305	286,457	3,661,354		3,661,354	(8,279)	3,653,075			10
10a	Therapy	135,325		12,717	148,042		148,042		148,042			10a
11	Activities	295,700	4,241		299,941		299,941	60	300,001			11
12	Social Services	125,905		10,457	136,362		136,362		136,362			12
13	Nurse Aide Training											13
14	Program Transportation			1,303	1,303		1,303		1,303			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,747,522	188,546	336,084	4,272,152		4,272,152	(8,219)	4,263,933			16
	C. General Administration											
17	Administrative	186,483		979,577	1,166,060		1,166,060	(953,678)	212,382			17
18	Directors Fees											18
19	Professional Services			377,705	377,705		377,705	173,919	551,624			19
20	Dues, Fees, Subscriptions & Promotions			170,983	170,983		170,983	(93,288)	77,695			20
21	Clerical & General Office Expenses	282,008	47,261	78,869	408,138		408,138	187,388	595,526			21
22	Employee Benefits & Payroll Taxes			1,052,282	1,052,282		1,052,282		1,052,282			22
23	Inservice Training & Education			10,818	10,818		10,818		10,818			23
24	Travel and Seminar			106	106		106	13,518	13,624			24
25	Other Admin. Staff Transportation			7,895	7,895		7,895		7,895			25
26	Insurance-Prop.Liab.Malpractice			326,769	326,769		326,769	331,486	658,255			26
27	Other (specify):*			179,066	179,066		179,066	(179,066)				27
28	**TOTAL General Administration**	468,491	47,261	3,184,070	3,699,822		3,699,822	(519,721)	3,180,101			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,383,633	763,337	3,846,846	9,993,816		9,993,816	(527,593)	9,466,223			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CRESTWOOD CARE CENTRE #0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			107,796	107,796		107,796	147,031	254,827			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			133,400	133,400		133,400	350,534	483,934			32
33	Real Estate Taxes			480,207	480,207		480,207		480,207			33
34	Rent-Facility & Grounds			1,182,600	1,182,600		1,182,600	(1,157,372)	25,228			34
35	Rent-Equipment & Vehicles			41,924	41,924		41,924	11,637	53,561			35
36	Other (specify):* STORAGE			4,178	4,178		4,178		4,178			36
37	TOTAL Ownership			1,950,105	1,950,105		1,950,105	(648,170)	1,301,935			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		212,952	368,718	581,670		581,670		581,670			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,933	166,933		166,933		166,933			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		212,952	535,651	748,603		748,603		748,603			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,383,633	976,289	6,332,602	12,692,524		12,692,524	(1,175,763)	11,516,761			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,605)	30		9
10	Interest and Other Investment Income	(1,840)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,442)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(355)	21		18
19	Entertainment	(69,269)	20		19
20	Contributions	(6,675)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,670)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(179,066)	27		24
25	Fund Raising, Advertising and Promotional	(9,493)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(10,286)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(24,194)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (332,895)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(842,868)	PG 6&6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (842,868)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,175,763)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CRESTWOOD CARE CENTRE

ID# 0044164

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (1,788)	6	1
2	VACATION ACCRUAL	(69)	1	2
3	VACATION ACCRUAL	3,646	3	3
4	VACATION ACCRUAL	1,578	4	4
5	VACATION ACCRUAL	(1,578)	6	5
6	VACATION ACCRUAL	(25,232)	10	6
7	VACATION ACCRUAL	60	11	7
8	VACATION ACCRUAL	0	17	8
9	VACATION ACCRUAL	(811)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,194)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(69)	0	0	0	0	0	0	0	0	0	0	(69)	1
2	Food Purchase	(1,442)	0	0	0	0	0	0	0	0	0	0	(1,442)	2
3	Housekeeping	3,646	0	0	0	0	0	0	0	0	0	0	3,646	3
4	Laundry	1,578	0	0	0	0	0	0	0	0	0	0	1,578	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,366)	0	0	0	0	0	0	0	0	0	0	(3,366)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	347	0	0	0	0	0	0	0	0	0	0	347	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(25,232)	16,953	0	0	0	0	0	0	0	0	0	(8,279)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	60	0	0	0	0	0	0	0	0	0	0	60	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(25,172)	16,953	0	0	0	0	0	0	0	0	0	(8,219)	16
	C. General Administration													
17	Administrative	0	(953,678)	0	0	0	0	0	0	0	0	0	(953,678)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,670)	8,422	168,167	0	0	0	0	0	0	0	0	173,919	19
20	Fees, Subscriptions & Promotions	(95,723)	2,435	0	0	0	0	0	0	0	0	0	(93,288)	20
21	Clerical & General Office Expenses	(1,166)	188,554	0	0	0	0	0	0	0	0	0	187,388	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	13,518	0	0	0	0	0	0	0	0	0	13,518	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	7,874	323,612	0	0	0	0	0	0	0	0	331,486	26
27	Other (specify):*	(179,066)	0	0	0	0	0	0	0	0	0	0	(179,066)	27
28	TOTAL General Administration	(278,625)	(732,875)	491,779	0	0	0	0	0	0	0	0	(519,721)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(303,450)	(715,922)	491,779	0	0	0	0	0	0	0	0	(527,593)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number CRESTWOOD CARE CENTRE **#** 0044164 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(27,605)	9,204	165,432	0	0	0	0	0	0	0	0	147,031	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,840)	0	352,374	0	0	0	0	0	0	0	0	350,534	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	25,228	(1,182,600)	0	0	0	0	0	0	0	0	(1,157,372)	34
35	Rent-Equipment & Vehicles	0	11,637	0	0	0	0	0	0	0	0	0	11,637	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(29,445)	46,069	(664,794)	0	0	0	0	0	0	0	0	(648,170)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(332,895)	(669,853)	(173,015)	0	0	0	0	0	0	0	0	(1,175,763)	45

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD		MANAGEMENT/
		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					MORTON GROVE	
				CRESTWOOD HEIGHTS NURSING CENTRE		
					MORTON GROVE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 16,953	$ 16,953	1
2	V	17	ADMINISTRATIVE	979,577	MR. BELLOWS OWNS 22% OF THIS FACILITY		25,899	(953,678)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		8,422	8,422	3
4	V	20	DUES & SUBSCRIPTIONS		" "		2,435	2,435	4
5	V	21	CLERICAL		" "		188,554	188,554	5
6	V	24	TRAVEL		" "		13,518	13,518	6
7	V	26	INSURANCE		" "		7,874	7,874	7
8	V	30	DEPRECIATION		" "		9,204	9,204	8
9	V	34	RENT		" "		25,228	25,228	9
10	V	35	RENT-EQUIPMENT		" "		11,637	11,637	10
11	V								11
12	V								12
13	V								13
14	Total			$ 979,577			$ 309,724	$ * (669,853)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 1,182,600	CRESTWOOD HEIGHTS NURSING CENTRE		$	$ (1,182,600)	15
16	V	19	ACCOUNTING FEES		" "		11,500	11,500	16
17	V	19	LEGAL		" "		567	567	17
18	V	19	OTHER PROFESSIONAL		" "		156,100	156,100	18
19	V	26	GENERAL INSURANCE		" "		299,979	299,979	19
20	V	26	MORTGAGE INSURANCE		" "		23,633	23,633	20
21	V	30	DEPRECIATION-BLDG IMP.		" "		150,905	150,905	21
22	V	30	DEPRECIATION-EQUIP, FURN.		" "		14,527	14,527	22
23	V	32	AMORTIZATION - MTG COST		" "		3,245	3,245	23
24	V	32	MORTGAGE INTEREST		" "		349,129	349,129	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,182,600			$ 1,009,585	$ * (173,015)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	22%	SEE ATTACHED	4.3	17.76	SALARY	25,899	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 25,899		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE
Phone Number: (847) 583 -0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	496,459	9	$ 95,479	$ 95,479	88,152	$ 16,953	1
2	17	ADMINISTRATIVE	PATIENT DAYS	496,459	9	145,864	145,864	88,152	25,899	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	496,459	9	47,431		88,152	8,422	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	496,459	9	13,714		88,152	2,435	4
5	21	CLERICAL	PATIENT DAYS	496,459	9	190,601		88,152	33,843	5
6	21	CLERICAL	HOURS	1	1	154,711	154,711	1	154,711	6
7	24	TRAVEL	PATIENT DAYS	496,459	9	76,130		88,152	13,518	7
8	26	INSURANCE	PATIENT DAYS	496,459	9	44,347		88,152	7,874	8
9	30	DEPRECIATION	PATIENT DAYS	496,459	9	51,835		88,152	9,204	9
10	34	RENT	PATIENT DAYS	496,459	9	142,084		88,152	25,228	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	496,459	9	65,539		88,152	11,637	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,027,735	$ 396,054		$ 309,724	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE						$	$			$	1
2	GMAC		X	MORTGAGE	$84,053.00	09/97	4,897,900	4,710,997	09/32	7.3750	349,129	2
3	GMAC		X	LOAN COST	AMORT - 35 YRS		113,573	96,537			3,245	3
4												4
5												5
	Working Capital											
6	AMERICAN NATL. BANK		X	WORKING CAPITAL	DEMAND	VARIES	323,671	1,050,000	DEMAND	PRIME+	47,245	6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	1,191,428	1,093,279	DEMAND	VARIES	75,690	7
8	LOAN FROM PARTNERS	X		WORKING CAPITAL	DEMAND	12/31/99	100,000	137,313	DEMAND	8.2500	10,465	8
9	TOTAL Facility Related				$84,053.00		$ 6,626,572	$ 7,088,126			$ 485,774	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,626,572	$ 7,088,126			$ 485,774	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 457,429	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 467,362	2
3. Under or (over) accrual (line 2 minus line 1).		$ 9,933	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 470,274	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 480,207	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	474,029	8
	1998	481,940	9
	1999	471,970	10
	2000	450,237	11
	2001	467,362	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible] Office of Health Finance at (217) 782-1600.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CRESTWOOD CARE CENTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044164

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-03-303-011-0000	NURSING HOME	$ 159,600.84	$ 159,600.84
2.	28-03-303-012-0000	NURSING HOME	$ 292,328.69	$ 292,328.69
3.	28-03-303-021-0000	NURSING HOME	$ 1,714.52	$ 1,714.52
4.	28-03-303-022-0000	NURSING HOME	$ 1,714.52	$ 1,714.52
5.	28-03-303-023-0000	NURSING HOME	$ 3,451.72	$ 3,451.72
6.	28-03-303-024-0000	NURSING HOME	$ 5,663.61	$ 5,663.61
7.	28-03-303-038-0000	NURSING HOME	$ 2,888.00	$ 2,888.00
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 467,361.90	$ 467,361.90

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,960 B. General Construction Type: Exterior STONE Frame STEEL Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	75,000	1972	$ 294,389	1
2	SEWER		1978	41,363	2
3	TOTALS	75,000		$ 335,752	3

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	303		1974	1974	$ 2,091,708	$ 26,548	35	$ 59,763	$ 33,215	$ 1,728,147	4
5			1980	1980	3,400		35	100	100	2,250	5
6	SEC 754 AJ			1992	584,054	18,541	31.5	18,541		194,683	6
7	SEC 754 AJ			2001	24,100	876	27.5	876		1,752	7
8											8
	Improvement Type**										
9	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE										9
10	REMODELING			1977	34,163		10			34,163	10
11	REMODELING			1980	12,383		10			12,383	11
12	IMPROVEMENTS			1984	38,466	1,349	20		(1,349)	38,466	12
13	IMPROVEMENTS			1985	18,271	934	10		(934)	18,271	13
14	IMPROVEMENTS			1985	1,200	62	20	60	(2)	1,050	14
15	IMPROVEMENTS			1985	32,506	1,691	15		(1,691)	32,506	15
16	IMPROVEMENTS			1986	76,557	3,982	20	3,828	(154)	63,156	16
17	IMPROVEMENTS			1986	16,943	881	10		(881)	16,943	17
18	IMPROVEMENTS			1986	1,559	81	25	62	(19)	1,023	18
19	IMPROVEMENTS			1987	23,951	761	20	1,198	437	18,560	19
20	IMPROVEMENTS			1987	22,863	726	20	1,143	417	17,717	20
21	IMPROVEMENTS			1988	20,627	1,406	20	1,031	(375)	10,788	21
22	IMPROVEMENTS			1989	35,057	432	31.5	1,113	681	15,405	22
23	IMPROVEMENTS			1990	50,320	1,598	31.5	1,598		19,514	23
24	IMPROVEMENTS			1991	53,090	1,684	31.5	1,684		19,082	24
25	IMPROVEMENTS			1992	53,668	1,704	31.5	1,704		17,924	25
26	IMPROVEMENTS			1992	51,711	3,447	31.5	3,447		35,763	26
27	IMPROVEMENTS			1993	42,479	1,090	15	1,090		10,110	27
28	IMPROVEMENTS			1993	78,601	2,495	39	2,495		24,370	28
29	IMPROVEMENTS			1994	193,211	7,026	27.5	7,026		55,213	29
30	FIRE ALARM SYSTEMS			1995	19,476	708	27.5	708		5,367	30
31	ELEVATOR REHAB			1995	57,000	2,072	27.5	2,072		15,190	31
32	NURSES CALL STATION			1995	6,318	230	27.5	230		1,685	32
33	DINING ROOM AIR CONDITIONING SYSTEM			1995	9,370	341	27.5	341		2,415	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	COOLING TOWER REPLACEMENT	1995	$ 15,650	$ 569	27.5	$ 569	$	$ 4,028	37
38	HAND RAILS/TILING ROOF	1996	103,547	3,765	27.5	3,765		24,775	38
39	HAND RAILS/TILING ROOF	1996	877	32	27.5	32		202	39
40	OUR TOWN	1996	61,800	2,247	27.5	2,247		13,101	40
41	REMODELING EXISTING STRUCTURE/SMOKE DOORS	1997	65,677	2,390	27.5	2,390		13,630	41
42	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1997	406,833	14,794	27.5	14,794		83,532	42
43	FIRE EXIT/REHAB/ROOF/OUR TOWN/WALLCOVERING	1997	44,213	1,607	27.5	1,607		8,885	43
44	WINDOW/OURTOWN/WALLCOVERING/FLOORS	1997	76,586	2,784	27.5	2,784		14,896	44
45	OUR TOWN	1998	32,000	1,164	27.5	1,164		5,771	45
46	ELECTRICAL WIRING FOR LAUNDRY AREA	1998	4,400	160	27.5	160		793	46
47	REMODELING - FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	35,000	1,273	27.5	1,273		6,312	47
48	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	900	33	27.5	33		163	48
49	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	9,604	349	27.5	349		1,731	49
50	AIR CONDITIONING SYSTEM	1998	17,900	651	27.5	651		3,119	50
51	ROOF REPAIRS	1998	2,790	101	27.5	101		484	51
52	BOILER VALVE	1998	5,450	198	27.5	198		800	52
53	WALLCOVERING	1999	2,206	80	27.5	80		387	53
54	METAL DOORS/OAK DOORS AND LOCKSETS	1999	6,267	228	27.5	228		730	54
55	OVERHANG WORK	1999	4,150	151	27.5	151		472	55
56	REMODEL - NURSES STATIONS	2000	25,135	914	27.5	914		2,323	56
57	A/C COMPRESSOR	2000	27,970	1,017	27.5	1,017		2,500	57
58	ROOF WORK	2000	11,384	414	27.5	414		949	58
59	REMODELING-DIALYSIS ROOM-PLUMBING, ELECTRICAL	2000	23,240	845	27.5	845		1,866	59
60	REMODEL - NURSES STATIONS	2000	10,730	390	27.5	390		829	60
61	CLOSET DOORS - 2, 3, AND 4TH FLOOR NURSES STATIONS	2001	1,900	69	27.5	69		135	61
62	PAINT LOCKER ROOMS AND RESIDENT BATHROOMS	2001	1,050	38	27.5	38		71	62
63	RENOVATE - 3A, 4B, AND 4A UTILITY ROOM CABINETS	2001	6,405	233	27.5	233		398	63
64	WANDERING ALERT SYSTEM - ALZHEIMERS UNIT	2001	17,525	637	27.5	637		1,035	64
65	DRYEALL AND PAINT - ROOM 226 AND BATHROOM	2001	1,883	68	27.5	68		105	65
66	ANTENNA SYSTEMS	2001	16,745	609	27.5	609		888	66
67	WANDERING ALERT SYSTEM - FIRST FLOOR	2001	13,650	496	27.5	496		517	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,706,519	$ 118,971		$ 148,416	$ 29,445	$ 2,609,323	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,706,519	$ 118,971		$ 148,416	$ 29,445	$ 2,609,323	1
2									2
3	REPLACE FIRST FLOOR DOUBLE DOORS	2001	3,150	115	27.5	115		120	3
4	KITCHEN FLOOR - REMOVE OLD AND INSTALL NEW TILE	2002	3,086	98	27.5	98		98	4
5	REPLACE 49 DOORS AND 1ST & 3RD FLR FIRE DOORS	2002	24,500	705	27.5	705		705	5
6	BUILD NEW SMOKING LOUNGE	2002	3,596	104	27.5	104		104	6
7	NEW CEILING GRIDS & WALLS FOR SMOKING LOUNGE	2002	3,292	95	27.5	95		95	7
8	INSTALL WALL COVERING - ROOM 223	2002	1,800	52	27.5	52		52	8
9	REBUILD AND PREP WALLS - RMS 234, 334 AND LOUNGE	2002	4,000	103	27.5	103		103	9
10	INSTALL DRYWALL & SOFFITS IN BATHROOM IN RM 306	2002	1,500	34	27.5	34		34	10
11	INSTALL NEW TRANSFER SWITCH FOR GENERATOR	2002	15,139	252	27.5	252		252	11
12	FLAT ROOF REPAIRS - LEAKS BY COOLING TOWER	2002	2,169	36	27.5	36		36	12
13	PARKING LOT - COMPLETE RECONSTRUCTION	2002	2,195	30	27.5	30		30	13
14	PARKING LOT - COMPLETE RECONSTRUCTION	2002	114,136	865	27.5	865		865	14
15									15
16									16
17									17
18			ADJ TO SL	29,445			(29,445)		18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,885,082	$ 150,905		$ 150,905	$	$ 2,611,817	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 777,078	$ 81,429	$ 73,599	$ (7,830)	3-10 YRS	$ 417,209	71
72	Current Year Purchases	131,833	26,367	6,592	(19,775)	3-10 YRS	6,592	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	559,713	23,731	23,731			485,495	74
75	TOTALS	$ 1,468,624	$ 131,527	$ 103,922	$ (27,605)		$ 909,296	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,689,458	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 282,432	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 254,827	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,605)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,521,113	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 27,063 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2002 JEEP CHEROKEE	$ 615.89	$ 10,062	17
18	FACILITY USE	2002 FORD CLUB WAG	675.97	4,799	18
19					19
20					20
21	TOTAL		$ 1,291.86	$ 14,861	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	Total Cost	
			Units of Service		Cost	Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 139,855	$		$ 139,855	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				39,118			39,118	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				189,285			189,285	4
5	Physician Care	39-3	visits				460			460	5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					171,918		171,918	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	X-RAY, LAB, RENTALS, I.V. THERAPY Other (specify):	39-2						41,034		41,034	13
14	TOTAL				$		$ 368,718	$ 212,952		$ 581,670	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 37,236	$ 569,015	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 49,373)	2,591,582	2,591,582	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,718	209,644	6
7	Other Prepaid Expenses	27,279	27,279	7
8	Accounts Receivable (owners or related parties)	12,975	1,031,518	8
9	Other(specify): ESCROW DEPOSITS		199,620	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,732,790	$ 4,628,658	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		477,487	13
14	Buildings, at Historical Cost		2,095,108	14
15	Leasehold Improvements, at Historical Cost		2,676,089	15
16	Equipment, at Historical Cost	884,504	884,504	16
17	Accumulated Depreciation (book methods)	(661,157)	(3,105,114)	17
18	Deferred Charges	7,246	103,783	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		399,362	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROG		315,941	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 230,593	$ 3,847,160	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,963,383	$ 8,475,818	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 555,215	$ 663,735	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	409,429	409,429	28
29	Short-Term Notes Payable		10,000	29
30	Accrued Salaries Payable	210,927	210,927	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,777	26,777	31
32	Accrued Real Estate Taxes(Sch.IX-B)		470,274	32
33	Accrued Interest Payable	248	248	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO IDPA	476,381	476,381	36
37	MANAGEMENT FEES	635,683	635,683	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,314,660	$ 2,903,454	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,280,592	1,258,680	39
40	Mortgage Payable		4,710,997	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,280,592	$ 5,969,677	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,595,252	$ 8,873,131	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,631,869)	$ (397,313)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,963,383	$ 8,475,818	48

***(See instructions.)**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,163,936)	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,163,934)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(505,484)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) 754 BASIS ADJ.	37,549	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (467,935)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,631,869)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,185,694	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,185,694	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,840	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,840	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,187,534	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,021,842	31
32	Health Care	4,272,152	32
33	General Administration	3,699,822	33
	B. Capital Expense		
34	Ownership	1,950,105	34
	C. Ancillary Expense		
35	Special Cost Centers	581,670	35
36	Provider Participation Fee	166,933	36
	D. Other Expenses (specify):		
37	NET VENDING COST	494	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,693,018	40
41	**Income before Income Taxes (line 30 minus line 40)****	(505,484)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (505,484)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,709	1,858	$ 62,596	$ 33.69	1
2	Assistant Director of Nursing	4,683	5,237	141,133	26.95	2
3	Registered Nurses	33,134	37,136	915,581	24.65	3
4	Licensed Practical Nurses	28,208	29,798	580,777	19.49	4
5	Nurse Aides & Orderlies	116,893	132,008	1,308,715	9.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,499	1,652	16,302	9.87	7
8	Rehab/Therapy Aides	8,140	9,112	119,023	13.06	8
9	Activity Director	3,373	3,769	60,246	15.98	9
10	Activity Assistants	18,697	20,103	235,454	11.71	10
11	Social Service Workers	7,954	8,672	125,905	14.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	13,936	15,728	204,518	13.00	14
15	Cook Helpers/Assistants	33,992	36,752	308,256	8.39	15
16	Dishwashers					16
17	Maintenance Workers	7,113	7,548	83,740	11.09	17
18	Housekeepers	33,233	37,333	420,598	11.27	18
19	Laundry	23,268	24,916	150,508	6.04	19
20	Administrator	2,064	2,064	112,775	54.64	20
21	Assistant Administrator	1,877	2,146	73,708	34.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,005	15,434	282,008	18.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	14,754	16,713	181,790	10.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	368,532	407,979	$ 5,383,633 *	$ 13.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	555	$ 21,035	1-3	35
36	Medical Director	348	25,150	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	1,400	58,540	10-3	38
39	Pharmacist Consultant	96	3,600	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	197	10,457	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,596	$ 118,782		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses	5,733	223,672	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	5,733	$ 223,672		53

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PATRICIA BARROWS	ADMIN		$ 112,775
DIANE WALKER	ASST ADMIN		73,708
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 186,483

B. Administrative - Other

Description		Amount
FIRST HEALTH CARE	MANAGEMENT FEES	$ 979,577
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 979,577

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		377,705
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 377,705

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,461
Unemployment Compensation Insurance	48,619
FICA Taxes	400,189
Employee Health Insurance	498,366
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	10,003
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	644
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,052,282

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	50,103
Health Care Worker Background Check	1,280
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	89,048
TRUST/FRANCHISE/CONTRIB/ETC	6,675
LICENSES & PERMITS	1,900
DUES & SUBSCRIPTIONS	21,977
MGMT CO ALLOCATION	2,435
TRUST/FRANCHISE/CONTRIB/ETC	(6,675)
Less: Public Relations Expense	(69,269)
Non-allowable advertising	(9,493)
Yellow page advertising	(10,286)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 77,695

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	106
RELATED PARTY	13,518
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,624

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	2000	$ 7,387	3	$	$ 1,231	$ 2,462	$ 2,462	$ 1,232	$	$	$	$
2	PAINT/DECORATING	2001	1,790	3			298	597	597	298			
3	PAINT/DECORATING	2002	5,817	3				970	1,939	1,939	969		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 14,994		$	$ 1,231	$ 2,760	$ 4,029	$ 3,768	$ 2,237	$ 969	$	$

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL COUNCIL ON LTC $18158.40**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,536** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **166,933**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: CRESTWOOD CARE CENTRE **#0044164** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	21,035	
	REPAIRS & MAINTENANCE		1,041	
			0	22,076
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		6,440	
			0	6,440
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		38,902	
	ELECTRICITY		79,549	
	WATER		23,897	
	CABLE TV - LOBBY		0	
			0	142,348
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,975	
	PAINTING & DECORATING		5,817	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		18,056	
	ELEVATOR MAINTENANCE & REPAIR		9,892	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,145	
	FIRE SERVICE		7,456	
	DEFERRED MAINTENANCE		1,449	
			0	
			0	54,790
7	**OTHER**			
	SCAVENGER		23,158	
	SECURITY SERVICE		77,880	101,038
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	25,150	25,150

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	223,672	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		645	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	3,600	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	58,540	
			0	
			0	286,457
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		8,545	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		4,172	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	12,717
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	10,457	
			0	10,457
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CRESTWOOD CARE CENTRE **#0044164** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,303	1,303
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	979,577	979,577
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	36,443	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	341,262	
			0	377,705
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	69,269	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	9,493	
	EMPLOYEE WANT ADS	XIX F	50,103	
	CONTRIBUTIONS	VI 20 XIX F	2,175	
	DUES & SUBSCRIPTIONS	XIX F	21,977	
	LICENSES & PERMITS	XIX F	1,900	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	10,286	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,280	170,983
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		8,332	
	EQUIPMENT REPAIR & MAINTENANCE		15,171	
	OUTSIDE CLERICAL SERVICES		212	
	PENALTIES / OVERDRAFT CHARGES	VI 18	355	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		806	
	TELEPHONE		53,545	
	MESSENGER SERVICE		448	
			0	78,869

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	400,189	
	UNEMPLOYMENT COMPENSATION	XIX D	48,619	
	WORKERS COMPENSATION INSURANC	XIX D	94,461	
	HOSPITALIZATION INSURANCE	XIX D	498,366	
	EMPLOYEE BENEFITS - OTHER	XIX D	10,003	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	644	
	CHICAGO HEAD TAX	XIX D	0	1,052,282
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		10,818	10,818
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	106	
			0	
			0	106
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,895	7,895
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		326,769	326,769
27	**OTHER**			
	BAD DEBTS	VI 24	179,066	
			0	179,066

GRAND TOTAL COLUMN 3 OTHER 3,846,846

CRESTWOOD CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	334,822	PATIENT MEALS	264456
LESS SALES TAX	(1,442)	ADD EMPLOYEE MEALS	0
NET FOOD	333,380	TOTAL MEALS/YEAR	264456
TOTAL PATIENT CENSUS	88,152	NET FOOD	333380
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	264456
TOTAL PATIENT MEALS	264456	COST PER MEAL	1.26
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

CRESTWOOD CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S									12,244,707	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	4,272,152	1,052,282	922,867	187,520	911,455	2,647,540	166,933	1,950,105		5,383,633
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	2,354		4,184			35,386		(41,924)		
CABLE TV			0			0				
CONTRACT NURSING										223,672
INTEREST INCOME							(1,840)			
NET VENDING COMMISSIONS							494			
EMPLOYEE PHYSICAL EXAMS		0				0				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(979,577)		979,577		
O2 INCOME/RENT INSURANCE						(299,979)		299,979		
BAD DEBTS						(179,066)	179,066			
DISCOUNTS LOST							0			
ANCILLARIES	581,670							0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	(296,747)	0	0	0	0	296,747	0	0		(112,775)
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	59,013	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	4,559,429	1,052,282	927,051	187,520	911,455	1,521,051	403,666	3,187,737	12,750,191	5,494,530
PER FINANCIAL STATEMENTS	4,559,429	1,052,282	927,051	187,520	911,455	1,521,051	403,666	3,187,737	(505,484)	5,494,530
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									(505,484)	

CRESTWOOD CARE CENTRE - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		111,288			113880			(2,592)	114192		
CENSUS DAYS		88,152			90266			(2,114)	91073		
OCCUPANCY %		79.21%			79.26%				79.75%		
SALARIES											
TOTAL General Services	8-1	1,167,620	10.14%	13.25	1133452	10.68%	12.56	34,168	1091650	11.04%	11.99
Social Services	12-1	125,905	1.09%	1.43	178041	1.68%	1.97	(52,136)	158366	1.60%	1.74
TOTAL Health Care and Programs	16-1	3,747,522	32.54%	42.51	3526356	33.22%	39.07	221,166	3295601	33.34%	36.19
Clerical & General Office Expenses	21-1	282,008	2.45%	3.20	317851	2.99%	3.52	(35,843)	287555	2.91%	3.16
TOTAL General Administration	28-1	468,491	4.07%	5.31	470348	4.43%	5.21	(1,857)	480887	4.86%	5.28
TOTAL Operation Expense	29-1	5,383,633	46.75%	61.07	5130156	48.33%	56.83	253,477	4868138	49.25%	53.45
ADJUSTED TOTALS											
Food	2-8	333,380	2.89%	3.78	378075	3.56%	4.19	(44,695)	381046	3.85%	4.18
Heat and Other Utilities	5-8	142,348	1.24%	1.61	186167	1.75%	2.06	(43,819)	166202	1.68%	1.82
Maintenance	6-8	201,572	1.75%	2.29	189891	1.79%	2.10	11,681	244969	2.48%	2.69
TOTAL General Services	8-8	2,022,189	17.56%	22.94	2053856	19.35%	22.75	(31,667)	2079274	21.03%	22.83
Administrative	17-8	212,382	1.84%	2.41	182745	1.72%	2.02	29,637	223904	2.27%	2.46
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0			
Professional Services	19-8	551,624	4.79%	6.26	486996	4.59%	5.40	64,628	372375	3.77%	4.09
Fees, Subscriptions, Promotions	20-8	77,695	0.67%	0.88	34419	0.32%	0.38	43,276	52719	0.53%	0.58
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0	200	0.00%	0.00
License Fee-Other	Pg21	1,900	0.02%	0.02	824	0.01%	0.01	1,076	11723	0.12%	0.13
Clerical & General Office Expenses	21-8	595,526	5.17%	6.76	634251	5.98%	7.03	(38,725)	597044	6.04%	6.56
Employee Benefits & Payroll Taxes	22-8	1,052,282	9.14%	11.94	972503	9.16%	10.77	79,779	862790	8.73%	9.47
Payroll Taxes	Pg21	448,808	3.90%	5.09	429946	4.05%	4.76	18,862	402968	4.08%	4.42
W/C Insurance	Pg21	94,461	0.82%	1.07	94734	0.89%	1.05	(273)	84110	0.85%	0.92
Health Insurance	Pg21	498,366	4.33%	5.65	394101	3.71%	4.37	104,265	307320	3.11%	3.37
Inservice Training & Education	23-8	10,818	0.09%	0.12	9716	0.09%	0.11	1,102	33209	0.34%	0.36
Travel and Seminar	24-8	13,624	0.12%	0.15	17736	0.17%	0.20	(4,112)	17156	0.17%	0.19
Other Admin. Staff Transportation	25-8	7,895	0.07%	0.09	11358	0.11%	0.13	(3,463)	9487	0.10%	0.10
Insurance-Prop.Liab.Malpractice	26-8	658,255	5.72%	7.47	257775	2.43%	2.86	400,480	188892	1.91%	2.07
Other (specify):*	27-8	0	0.00%	0.00	0	0.00%	0.00	0			
TOTAL General Administration	28-8	3,180,101	27.61%	36.08	2607499	24.57%	28.89	572,602	2357576	23.85%	25.89
TOTAL Operation Expense	29-8	9,466,223	82.20%	107.39	8752637	82.46%	96.96	713,586	8193573	82.89%	89.97
Real Estate Taxes	33-3	480,207	4.17%	5.45	396526	3.74%	4.39	83,681	473902	4.79%	5.20
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	17065	0.17%	0.19
GRAND TOTAL COST	45-8	11,516,761	100.00%	**130.65**	10614480	100.00%	**117.59**	902,281	9885136	100.00%	**108.54**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		4469801.37	38.81%	**50.71**	3992877.9	37.62%	**44.23**	476,923	3852763.9	38.98%	**42.30**

CRESTWOOD CARE CENTRE - DIAGNOSTICS - 12/31/2002

This report DOES NOT REFLECT a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 4029 from Page 22 and -5817 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-352374
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-174636
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.